

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04091

166

4088

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Barrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 3 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, Md. <input checked="" type="checkbox"/>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Mary	Middle McRobie	Last Brooks	4. DATE OF DEATH April	Month 16,	Day Year 1957		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1880	9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Swanton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Francis M. McRobie				14. MOTHER'S MAIDEN NAME Lucy McRobie					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lee Lucas, Bayard, W. Va.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)				19. INTERVAL BETWEEN ONSET AND DEATH					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>April 15, 1957</u> to <u>April 16, 1957</u> , that I last saw the deceased alive on <u>April 15, 1957</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>E. J. Baumgardner</u> PHYSICIAN'S NAME (Type) <u>E. J. Baumgardner</u>		M.D.		ADDRESS (Street, city or town, state) <u>3500 East Baltimore</u>		DATE SIGNED <u>4/10/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 20, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Deer Park		22d. LOCATION (City, town, or county) (State) Deer Park, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <u>McAuliffe</u>		ADDRESS Balden Funeral Home Oakland, Md.		24a. RECEIVED BY REGISTRAR DATE <u>4/20/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julia Rowan</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

CEMETERY OF DEATH

BUREAU V. S

APR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

07898
11

4'89 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK		c. LENGTH OF STAY IN 1b 60 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO DEER PARK	
3. NAME OF DECEASED (Type or print) SAMUEL		4. DATE OF DEATH Month APRIL Day 13 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 4, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PAINTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) GREENGLADE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARCHIBALD BROWNING		14. MOTHER'S MAIDEN NAME KATHRYN FRAZEE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 17. INFORMANT MR. VAN BROWNING Address DEER PARK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 12 p.m. Month Apr 13 Day 1957 Year 1957		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 77 Oak Street	
21. I certify that I attended the deceased from April 16, 1957 to Apr 13, 1957 , that I last saw the deceased alive on April 13, 1957 , and that death occurred at 11:26 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Herbert H. Leighton M.D. ADDRESS (Street, city or town, state) 77 Oak Street DATE SIGNED April 15, 1957			
PHYSICIAN'S NAME (Type) Herbert H. Leighton		Oakland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/16/57	
22c. NAME OF CEMETERY OR CREMATORIAL DEER PARK		22d. LOCATION (City, town, or county) DEER PARK (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Bellakos		24a. REC'D. BY REGISTRAR 11/16/57	
ADDRESS BOLDEN FUNER HOME OAKLAND		24b. REGISTRAR'S SIGNATURE J. J. D. Fowen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED - 1957 APR 19 1957

RECEIVED
FBI - BUREAU OF INVESTIGATION

APR 19 1957

BUREAU OF INVESTIGATION

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04094

CERTIFICATE OF DEATH

4090

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (In this place) Lifetime	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Selbysport		COUNTY Garrett (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS /		
3. NAME OF DECEASED (First) (Middle) (Last)			4. DATE (Month) (Day) (Year) OF DEATH 4 4 57		
S. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 4/16/1878	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Deys
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper			10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Winfield Scott Friend			14. MOTHER'S MAIDEN NAME Eva Ellen Laughrey		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Miss. Agnes Frazee, Selbysport	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 450.0 IMMEDIATE CAUSE (A) <i>Arterio Sclerosis</i> ANTECEDENT CAUSE(S) DUE TO: _____ DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO: _____ (C) <i>Rheumatic Deformans</i> <i>Senility</i> INTERVAL BETWEEN ONSET AND DEATH <i>80 years</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1950</i> , 19, to <i>Apr. 4, 1957</i> , that I last saw the deceased alive on <i>Mar. 30, 1957</i> , and that death occurred at <i>1130 AM</i> from the causes and on the date stated above. SIGNATURE <i>H.B. Messmore</i> ADDRESS (Street, city, town, state) <i>1933 Addison - 102</i> DATE SIGNED <i>1957</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/7/1957	NAME OF CEMETERY OR CREMATORIAL Friendsville	LOCATION (City, town, or county) Friendsville (State) Md.	
24. REC'D BY REGISTRAR DATE <i>April 6, 1957</i>		REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		
			<i>Jack S. Friend, Friendsville</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04095

4091

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Oakland		c. LENGTH OF STAY IN 1b 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Oakland Xo		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Catherine	Middle	Last Georg	4. DATE OF DEATH Month April	Day 28	Year 1957
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 30, 1878	9. AGE (In years lost birthday) yrs. 79	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Accident, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Christian Bietzel				14. MOTHER'S MAIDEN NAME Susan Bowman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Fred Glotfelty		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic C-V Disease INTERVAL BETWEEN ONSET AND DEATH 422.1 10 years DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 hours , 19 45 , to 28 April , 19 57 , that I last saw the deceased alive on 26 April , 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 28 April 1957							
ACTUAL SIGNATURE A. E. Mance		M.D.					
PHYSICIAN'S NAME (Type) A. E. Mance, M. D.		Oakland, Maryland 28 April, '57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Accident		22d. LOCATION (City, town, or county) Accident (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bolden Funeral Home		ADDRESS Oakland, Md. 24a. REC'D BY REGISTRAR 5/1/57 24b. REGISTRAR'S SIGNATURE Julia Mance Xo					

STATE GOVERNMENT OF NEVADA - BUREAU OF INVESTIGATION		CERTIFICATE OF DEATH	
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RECEIVED
BUREAU

MAY 3 1957

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04097

4092 CERTIFICATE OF DEATH

Item 13 Film 0213 4-12-57 et

Reg. Dist. No. 172

1. PLACE OF DEATH CITY OR TOWN HOSPITAL INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED CITY OR TOWN STREET ADDRESS	
GARRETT RITZMILLER OAK STREET		MARYLAND KITZMILLER OAK STREET	
3. NAME OF DECEASED (Type or Print) (First) SAMUEL		(Middle) ALONZO	
(Last) HADDIX		4. DATE OF DEATH APRIL 2, 1957	
5. SEX MALE	6. COLOR OR WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 22, 1869
9. AGE last birthday 88 yrs.	10. KIND OF BUSINESS OR INDUSTRY COAL MINES	11. BIRTHPLACE (State or foreign country) Grafton, W.Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Adam Haddix	14. MOTHER'S MAIDEN NAME JULIA ANN KERNS	15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (Yes, no, unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Mrs. Annie Haddix, Kitzmiller, Md.	
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (A) Acute Myocarditis (B) Coronary Heart Disease (C) None			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Penicillin Allergy			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		21g. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
22. I hereby certify that I attended the deceased from <u>April 2, 1957</u> , to <u>April 2, 1957</u> , that I last saw the deceased alive on <u>April 2, 1957</u> , and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>John Colquhoun</u> M.D. <u>Kitzmillier, Md</u> DATE SIGNED <u>April 2-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/5/57	
24. REC'D BY REGISTRAR DATE 1/14/57		REGISTRAR'S SIGNATURE Ani Barich	
25. FUNERAL DIRECTOR'S SIGNATURE O. J. Shortless		ADDRESS Blaine, W.Va.	
LOCATION (City, town, or county) Elk Garden, W.Va.		(State)	

RECEIVED BY THE LIBRARY OF THE STATE OF HAWAII

LIBRARY OF STATE

BUREAU V. 8

APR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4093

CERTIFICATE OF DEATH

01099

Reg. Dist. No. 16

1. PLACE OF DEATH
a. COUNTY

GARRETT

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

OAKLAND

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

WEEKS NURSING HOME

3. NAME OF
DECEASED
(Type or print)

FRANKLIN

First

Middle

Last

4. DATE
OF
DEATH

APRIL

Month

Day

Year

1957

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

FEB-22-1886

9. AGE (In years
lost, birthday)

77 yrs

10. IF UNDER 1 YEAR
Months Days Hours Min10a. USUAL OCCUPATION (G ve kind of work done
during most of working life, even if retired)

RETIRED FARMER

10b. KIND OF BUSINESS OR INDUSTRY

THAYERVILLE

11. BIRTHPLACE (State or foreign country)

THAYERVILLE

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

WILLIAM KIMMELL

14. MOTHER'S MAIDEN NAME

JENNY BOWSER.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

CLAUDE KIMMELL CUMBERLAND, MD.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)151X • 08/14/57
DUE TO

Carious of stomach

INTERVAL BETWEEN
ONSET AND DEATH

1-7

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

Arteriosclerotic heart disease

years

DUE TO

(c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 1-1, 1957, to 7-6, 1957, that I last saw the deceased alive on 4-6, 1957, and that death occurred at 12:00 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

M.D. 58 21 st. Oakland 4-8-57

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

APR 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 104101

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND		b. COUNTY GARRETT	
c. LENGTH OF STAY IN 1b 16		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GORMANIA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS ROUTE #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EMMA		First MIDDLE MAY	Last MIDDLE MARTIN
4. DATE OF DEATH APRIL 18		Month 19	Day 57
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3/2/96		9. AGE (In years lost birthday) 81 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) BARTON, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME FRANK KYLE		14. MOTHER'S MAIDEN NAME ANNA MAY LEE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO 17. INFORMANT CARL C. ATHEY? Box 1 25, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4d. d. 1 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 16 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 Apr</u> 1957 to <u>4/18/18</u> , 1957, that I last saw the deceased alive on <u>4/18/18</u> , 1957, and that death occurred at <u>9:05 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Andrew E. Mance</u> M.D.		ADDRESS (Street, city or town, state) <u>Oakland Md</u> DATE SIGNED <u>18 Apr 18</u>	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M. D.		OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/21/57	
22c. NAME OF CEMETERY OR CREMATORIUM Laural Hill		22d. LOCATION (City, town, or county) (State) MOSCOW, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. G. Anderson</u>		24a. REC'D BY REGISTRAR DATE <u>4/18/57</u>	
ADDRESS Golden Funeral Home Oakland, Md.		24b. REGISTRAR'S SIGNATURE <u>Julia O. Brown</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

APR 30 1957

RECEIVED

CERTIFICATE OF DEATH

4095

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Garrett MARYLAND CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Friendsville LENGTH OF STAY (in this place) 3 years				2. USUAL RESIDENCE (HOME) OF DECEASED STATE W. Va. COUNTY Mongolia CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Morgantown STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) Malissie Rachel McCartney				4. DATE OF DEATH 4 22 1957			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
Female	White	Widowed	June 30, 1879	77 yrs.	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (State or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Scott Dobbins				14. MOTHER'S MAIDEN NAME Katherine Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Coronary occlusion ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Heart Disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) Thrombophlebitis left leg -2 months STATING UNDERLYING CAUSE LAST.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1954</u>, 19, to <u>April 16, 1957</u>, that I last saw the deceased alive on <u>April 16, 1957</u>, and that death occurred at <u>12:00 P.M.</u> from the causes and on the date stated above. SIGNATURE <i>Barroed Diamond, M.D.</i> ADDRESS (Street, city, town, state) <i>R.D. Markleyburg, Apt. 5</i> DATE SIGNED <i>5/7/57</i> 							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/24/57		NAME OF CEMETERY OR CREMATORIUM Hallack Cemetery		LOCATION (City, town, or county) <i>Near Morgantown, W. Va.</i> (State) <i>57</i>	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE DATE <i>April 12, 1957</i> 11:00 A.M. Kelli Tracy				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Jack A. Fiedler, Friendsville</i>			

BUREAU N.Y.

APR 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4996 CERTIFICATE OF DEATH

Reg. Dist. No. 186

04103

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND	c. LENGTH OF STAY IN 1b 3 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		d. STREET ADDRESS Box 42	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Oscar	First Adam	Middle Shaffer	Last 4. DATE OF DEATH 4 19 1885
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-1885
9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal	
10c. BIRTHPLACE (State or foreign country) West Virginia		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Shaffer, Daniel		14. MOTHER'S MAIDEN NAME Saucer, Ellen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 218-10-753	
17. INFORMANT "Gladys Graham Shaffer (Wife) Box 42, Crellin, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Carcinoma Lung Bilateral		INTERVAL BETWEEN ONSET AND DEATH 6 Days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Carcinoma Lung Bilateral (c)		6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/22/45</u> to <u>19 apr 57</u> that I last saw the deceased alive on <u>19 apr 57</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andrew E. Mance</u>		ADDRESS (Street, city or town, state) Oakland, Md.	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.		DATE SIGNED 20 apr 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/57	
22c. NAME OF CEMETERY OR CREMATORIAL Oakland		22d. LOCATION (City, town, or county) Oakland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>1. Bolden</u>		ADDRESS Bolden Funeral Home Oakland, Ma.	
24a. REG'D BY REGISTRAR DATE 4/22/57		24b. REGISTRAR'S SIGNATURE Julie. O'Ferrell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 20 1957

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05215

4097

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		c. LENGTH OF STAY IN 1b 16 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Missouri		First	Middle	Last	4. DATE OF DEATH April 29, 1957	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1866	9. AGE (in years last birthday) 90 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	13. Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Nine		14. MOTHER'S MAIDEN NAME Arthelia Shaw						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. —		17. INFORMANT Harry Speicher		Address Deer Park, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.0		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Brancho pneumonitis Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)						15 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Oakland		(County) (State)
21. I certify that I attended the deceased from Feb. 13, 1948, to April 29, 1957, that I last saw the deceased alive on April 29, 1957, and that death occurred at 9:30 P. M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Oakland		DATE SIGNED 30 April 1957
ACTUAL SIGNATURE A. E. Mance, M. D.								
PHYSICIAN'S NAME (Type) A. E. Mance, M. D.						Oakland, Maryland		30 April 1957
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/2/1957		22c. NAME OF CEMETERY OR CREMATORIAL Paradise Cemetery		22d. LOCATION (City, town, or county) near Deer Park, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton		ADDRESS Oakland, Md.		24a. REC'D. BY REGISTRAR 1957 Julia Rowan		24b. REGISTRAR'S SIGNATURE Herbert C. Leighton		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, it should be forwarded to the funeral director. page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y, 2

MAY 10 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained by the funeral director, the third copy of this death certificate assembly should be retained by the funeral director.

VS AISC 1-51 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04106

4998 CERTIFICATE OF DEATH

Reg. Dist. No. 172

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY GARRETT		MARYLAND		STATE MARYLAND COUNTY GARRETT	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN RURAL- VINDEX		LENGTH OF STAY (In thousands) 8 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) OR. TOWN Rural- Vindex	
HOSPITAL OR INSTITUTION OR STREET ADDRESS West Vindex			STREET ADDRESS (If rural give location) West Vindex		
3. NAME OF DECEASED (Type or Print) SANDRA DARLENE STEWART			4. DATE OF DEATH APRIL 5, 1957		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, W. DIVORCED, (Specify) Single	8. DATE OF BIRTH Feb. 9, 1949	9. AGE last birthday 8 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY 2nd. Grade	11. BIRTHPLACE (State or foreign country) West Vindex, Md.	
13. FATHER'S NAME WILLIAM ALBERT STEWART			14. MOTHER'S MAIDEN NAME MARCELLA KATHERN BROWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> unk)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS WM. A. STEWART, Star Route Kitzmiller, Md.	
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Cardio - Vascular heart Disease</u> ANTECEDENT CAUSE(S) DUE TO <u>with marked edema</u> DISEASES OR CONDITIONS, IF ANY, (B) <u>Chronic Hepatitis</u> GIVING RISE TO THE ABOVE CAUSE DUE TO <u>6 mos.</u> STATING UNDERLYING CAUSE LAST. (C) <u>2 years</u> II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 19, 1954</u> to <u>April 5, 1957</u> , that I last saw the deceased alive on <u>April 5, 1957</u> , and that death occurred at <u>6:10 AM</u> from the causes and on the date stated above. SIGNATURE <u>W. A. Stewart</u> M.D. ADDRESS (Street, city, town, state) <u>Kitzmiller, Md.</u> DATE SIGNED <u>April 8, 1957</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/8/57		NAME OF CEMETERY OR CREMATORIUM I.O.O.F. Cemetery	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE A. Barwick		25. FUNERAL DIRECTOR'S SIGNATURE Otha F. Shaeffer	
DATE 4/8/57				ADDRESS Blaine, W. Va.	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 2 OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 OAKLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS 7 SECOND STREET		e. DATE OF DEATH APRIL 10, 1957		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARA	First A.	Middle STUCK	Last STUCK	Month APRIL	Day 10	Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/1888	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POINT OF ROCKS, MD.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE BROWN				14. MOTHER'S MAIDEN NAME ADALINE WRIGHT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. MR. GEORGE STUCK, 7 SECOND STREET-OAKLAND, MD.,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X DUE TO Coronary Heart Disease INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis ONSET AND DEATH (c) diabetes Mellitus 10 yrs 10 yrs 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from app. , 19 50 , to April 10, 1957 , that I last saw the deceased alive on April 11, 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D. ADDRESS (Street, city or town, state) Oakland MD DATE SIGNED 11 Apr 57							
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.		OAKLAND, MARYLAND					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 13, 1957		22c. NAME OF CEMETERY OR CREMATORIAL POINT OF ROCK		22d. LOCATION (City, town, or county) POINT OF ROCK (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John E. Mance		24a. REC'D. BY REGISTRAR 4/12/57		24b. REGISTRAR'S SIGNATURE John E. Mance			

BUREAU V. A.

APR 11 1962

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04108

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEAR GRANTSVILLE		c. LENGTH OF STAY IN 1b —	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —		e. CITY OR TOWN (If, outside corporate limits, write RURAL and give nearest town) NEAR GRANTSVILLE	
3. NAME OF DECEASED (Type or print) LATRY		First MARVIN	Middle WARNICK
4. DATE OF DEATH APRIL 29 1957	Month Month	Day Day	Year Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 28 1952
9. AGE (in years last birthday) 44	10. IF UNDER 1YEAR Months —	11. IF UNDER 24 HRS. Days —	12. IF UNDER 24 HRS. Hours —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MEYERSDALE Comm Hosp	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME MARVIN WARNICK	14. MOTHER'S MAIDEN NAME MARY JURST	Address M Marvin Warnick, Grantsville, Md	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —	16. SOCIAL SECURITY NO. —	17. INFORMANT —	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CRUSHING INJURY LEFT OCCIPITAL PORTION OF SKULL
Condition, if any, which gave rise to immediate cause (a), stating the underlying cause first. —		DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH —
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH fall out of car	20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of Item 18.] Run over by right front wheel		
20c. TIME OF INJURY Hour 3 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) farm	20f. (City or town) Donuts nle Garrett
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> S. J. Baumgartner			
ACTUAL SIGNATURE S. J. Baumgartner		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY 1 1957	22c. NAME OF CEMETERY OR CREMATORIAL METHODIST CEM	22d. LOCATION (City, town, or county) (State) NEW Germany-GARRETT CO MD
23. FUNERAL DIRECTOR'S SIGNATURE Donald F. Newman, Grantsville, Md	ADDRESS —	24a. REC'D BY REGISTRAR DATE MAY 6 1957	24b. REGISTRAR'S SIGNATURE —

■ DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal, or removal.

BUREAU V. S.

✓ 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4101

CERTIFICATE OF DEATH

Reg. Dist. No.

06169

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND.		c. LENGTH OF STAY IN 1b 2 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. STREET ADDRESS BAYARD 85X-3	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle A.	Last WILLIAMS
4. DATE OF DEATH APRIL 15	Month 1957	Day 15	Year 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 11/1/82	9. AGE (In years lost birthday) 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER Retired		10b. KIND OF BUSINESS OR INDUSTRY Soft COAL	11. BIRTHPLACE (State or foreign country) MARYLAND, U.S.A.
12. CITIZEN OF WHAT COUNTRY? MARYLAND, U.S.A.			
13. FATHER'S NAME ANDREW WILLIAMS		14. MOTHER'S MAIDEN NAME MARTHA FREELAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 232-03-2228	17. INFORMANT Mrs. Lela Williams
		Address Ba yard, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH 6 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 8, 1956 , to April 15, 1957 , that I last saw the deceased alive on April 14, 1957 , and that death occurred at 7:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph Alvarez</i>		ADDRESS (Street, city or town, state) Oakland, Maryland	
PHYSICIAN'S NAME (Type) JOSEPH ALVAREZ M.D.		DATE SIGNED 4/16/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/1957	
22c. NAME OF CEMETERY OR CREMATORIAL Bayard Cemetery		22d. LOCATION (City, town, or county) (State) Bayard, Grant Co., W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert C. Daugherty</i>		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE 4/17/57		24b. REGISTRAR'S SIGNATURE <i>George</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CEMETERIC OF BEAUM

AMERICAN STATE GOVERNMENT OF THE UNITED STATES

BUREAU V. S.

APR 30 1957

RECEIVED

04/11/57

Reg. Dist. No.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4102 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN lb 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XI ACCIDENT	
3. NAME OF DECEASED (Type or print) WILHELM		First WILHELM	Middle
4. DATE OF DEATH APRIL 14		Lost ZINKAN	Month Day Year 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 3/31/77
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years lost/birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY own farm	
11. BIRTHPLACE (State or foreign country) Accident, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY ZINKAN		14. MOTHER'S MAIDEN NAME ELLEN MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Waldo Zinkan, Accident, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) (c)		DUE TO Congestive Heart failure Anterior sclerosis	
		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 9, 1954 to Apr 14, 1957 that I last saw the deceased alive on APRIL 14, 1957 , and that death occurred at 5:55 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 3520 E. 25th Street DATE SIGNED 4/15/57	
ACTUAL SIGNATURE <i>S. I. Baumgartner</i>		M.D.	
PHYSICIAN'S NAME (Type) E. I. BAUMGARTNER, M. D.		OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/57	
22c. NAME OF CEMETERY OR CREMATORIAL St Paul's		22d. LOCATION (City, town, or county) Accident, Garrett Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Donald J. Newman</i>		24a. REC'D. BY REGISTRAR 4/16/57	
		24b. REGISTRAR'S SIGNATURE <i>Donald J. Newman</i>	

CERTIFICATE OF DEATH

WILLIAM CLAUDE DEHAUNIAC, JR.

John & Freda - 1957

BUREAU V. S.

APR 18 1957

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